NASSAU HEALTH CARE CORPORATION
NASSAU UNIVERSITY MEDICAL CENTER
Non-Employee Information Form

Please indicate anticipated status:

☐ Rotating Resident [22333]	☐ Medical Student [22331]	☐ PA Student [22332]
☐ Podiatry Student [22332]	☐ PT Student [22332]	☐ OT Student [22332]
☐ Rad Tech Student [22332]	☐ SW Intern [22332]	☐ Ultrasound Intern [22332]
☐ Ther Rec Student [22332]	☐ Intern [22332]	☐ Extern [22332]
☐ Other Student [22332]	☐ Contract Worker	☐ Volunteer

Please complete this form in its entirety.

Name____ **Birth Date**________________________
Last Name First Name M.I. Month/Day/Year

Address:____
Street City State Zip

Social Security #_________________________________ **Gender: ____Male ____Female**

Email Address:___________________________________ **Telephone#:** ________________________
___Cell ___ Home ___ Work

Emergency Contact Information

Name: ____ **Relationship**: _______________________

Contact Number: _________________________________
___Cell ___ Home ___ Work

Ethnic Group: ___White ___Black ___Hispanic ___Asian or Pacific Islander
___American Indian or Alaskan Native ___Other ______________

Are you able to perform the essential functions of the position for which you are applying with or without an accommodation: ___Yes ___ No **Requested Accommodations**: __________________________

Referral Source:

School Name: _________________________________ **Institution:** ________________________________

Anticipated Graduation Date: __________________

Reporting to:
Department's Name: __________________________ **How Long Will You Be @ NUMC?**______

Please List Rotations Separately:

Department	Supervisor	Start Date	End Date
____________________	____________________	__________________	___________________
____________________	____________________	__________________	___________________
____________________	____________________	__________________	___________________

Date Of Last Physical Exam: ____________ (All paperwork must be submitted to the Employee/Occupational Health Department)

Foreign Languages (fluent): ____

Professional Degree: ____

Professional License Type: _________________ License #:______________ Exp. Date: ____________
(Copy Must be Attached)

Parking Information: (for Security Purposes)

Car Make_________________ Car Type:________________ Car Color:____________

Plate #: __________________ State:_____________________

I affirm that my answers to the questions in this application are true and correct and I understand that any misrepresentation will be cause for immediate termination of services or grounds for dismissal.

I authorize Nassau Health Care Corporation to contact my former employers and academic institutions attended for verification.

____ ________________________________
Signature of Non-Employee Date
(Student, Contractor, Volunteer, etc.)

____ ________________________________
Signature of Authorized Department Representative Date

Lawson Dept. # _______________________________ MC # ___________________________

____ ________________________________
Signature of Human Resources Representative Date entered to Lawson System